BRITISH MEDICAL JOURNAL

LONDON SATURDAY SEPTEMBER 1 1962

THE DOCTOR'S CODE*

BY

Sir DAVID CAMPBELL, *M.C.*, M.D., LL.D., D.C.L., F.R.C.P.
Past-president of the General Medical Council

There are few in these islands to-day who do not recognize the imperative necessity of securing within the limits of our resources a more effective and wider application of medical knowledge and service, a better distribution of the economic burden of illness, greater emphasis on the prevention of disease, and an improved and more economical co-ordination of medical activities. To secure these ends, questions of finance and of organization have arisen, and will continue to arise, which are of great public concern. But important as they are, they are not in my view of paramount significance. What is of the greatest importance is the quality of the medical care given to the public. Whatever the administrative structure of the health services may be, they will be judged not so much by the plan of organization, nor by the methods of finance and control, but by the quality of the medical care offered to the people. In the last analysis that depends upon the intelligent interpretation and correlation of scientific knowledge in its application to the needs of the individual, and on the moral qualities of those who serve. In short, medical education and medical ethics have always been, and will continue to be, the most important factors in determining the degree of success of any health service.

These were some of the reasons which led me, when I was honoured by being invited to deliver the Sir Charles Hastings Lecture, to welcome the suggestion that I should speak of the powers, the duties, the work, and the influence of the General Medical Council, in these days inevitably known as the G.M.C. For the name given by the Medical Act of 1858, which established the Council over which I had the honour to preside for 12 years, was the General Council of Medical Education and Registration of the United Kingdom, and for more than 100 years it has been responsible to Parliament and to the public for the codes, both educational and ethical, of the doctors in these islands.

Many Misconceptions

There was another reason. There is probably no body about which there are so many misconceptions in the minds of lay people and even of medical practitioners. Both within and without the profession misunderstanding and confusion exist regarding the Council's functions and limitations.

According to the writers of certain sensational novels and in some of the more flamboyant organs of the press, the G.M.C., because of its disciplinary work, has been pictured as a miniature Star Chamber. It is very often confused with the British Medical Association, with which it has nothing whatever to do. I need hardly remind some of this audience that the B.M.A. is a voluntary association of medical men and women established to look after professional interests, which in its own sphere does excellent work.

But the General Medical Council is, in fact, neither a Star Chamber nor an association for protecting professional interests. It is a Statutory Body established by Act of Parliament in 1858 and charged with certain duties and responsibilities. In the classic phrase of the first President, Sir Benjamin Brodie, it is "a coadjutor of the Government in one department of the public business."

It may surprise some of you to learn that when the Council was created 104 years ago the declared purpose of Parliament was *not* to promote the welfare of professional men nor of professional corporations such as the Royal Colleges; it was *not* to put down quackery or even to advance medical science. The object was simply the interest and protection of the public. The preamble to the Act of 1858 consists of two lines only:

> "Whereas it is expedient that persons requiring medical aid should be enabled to distinguish qualified from unqualified practitioners. Be it therefore enacted . . ."

The preamble, you will see, recognizes two kinds of practitioners, the "qualified" and the "unqualified." Up to that time no easily understood line was drawn between the two, and when the public desired to make a choice they were frequently at a loss. Why was this so? To answer that question we must look at the state of affairs before 1858.

Conditions Before the 1858 Act

The first half of last century saw the medical profession of Great Britain and Ireland in a state almost approaching chaos. There was no cohesion among the several branches of the profession, torn as they were by jealousies and competing interests. In simple fact, Medicine as a unified profession did not exist. Uneducated and half-educated practitioners flourished. Those members of the profession eager for reform had for long been alarmed at the situation. Outstanding among them was the man in whose memory this lecture was founded, Charles Hastings. For one of the chief objects of the Provincial Medical and Surgical Association formed under his skilful leadership in 1832, and which later became the B.M.A., was medical reform. The Medical Reform Committee established by him in 1837 insisted that all persons attending the sick in any capacity should be properly educated and tested before being licensed to practise, and that regulations should be made for the benefit of the community as a whole—surely reasonable desiderata. Yet 21 years passed and

*The Sir Charles Hastings Lecture given at Queen's University, Belfast, on July 26.

no fewer than 17 reforming Bills were rejected by Parliament before the Medical Act of 1858 became law.

In a remarkable memorandum prepared that year, the great medical administrator, John Simon, painted an astonishing picture. "Titles," he wrote, "purporting to certify the medical attainments of their bearers may at the present moment be obtained from twenty-one different sources within the United Kingdom, including the Archbishop of Canterbury. These titles are given entirely without concert among the several institutions which award them and without responsibility to any common authority. They represent twenty-one different standards each fixed and varied at the discretion of the authority which applies it of what is the minimum knowledge wherewith a candidate may properly be allowed to practise all or part of his profession; so that 'Doctor' and 'Physician' and 'Surgeon' are words that have no general and settled meaning either as to the kind and degree of education implied in each title respectively or as to the sufficiency of the examination through which the bearer has passed."

There was, too, irresponsible competition among licensing bodies, universities, and examining boards alike. Some universities had even been suspected of selling their degrees. Some of the examining bodies derived a great part or the whole of their income as payment for the titles which they bestowed, and were tempted to attract by lower fees and more indulgently conducted examinations candidates who preferred to resort to those where the requirements were least.

Some titles purported to be given after examination in all branches of the profession and to guarantee their bearers qualifications equally in all. Others merely expressed that their bearers had been examined only in one branch. Thus in 1856 Simon noted that more than one-fifth of the Members of the Royal College of Surgeons of England possessed no second title and might therefore be unable to offer any competent knowledge of the practice of medicine or of midwifery, while a seventh of the Licentiates of the Society of Apothecaries were apparently unpossessed of any diploma to guarantee their knowledge even of the rudiments of surgery.

You must add to that the gross anomalies which prevailed throughout the United Kingdom in the relative position of the licensing bodies to each other. Exclusive privileges were possessed in cities and provinces by the medical corporations which none could invade without being exposed to a rigorous prosecution. To mention only a few of these monopolies. (1) Graduates of Irish and Scottish universities had no legal rights to practise in England. (2) Graduates of English universities could not practise as physicians in London and seven miles round, which was under the special jurisdiction of the London College of Physicians. (3) In Scotland the Faculty of Physicians and Surgeons of Glasgow had an exclusive jurisdiction so far as surgery was concerned over certain counties in the west, while the Royal College of Surgeons of Edinburgh held similar sway in the east. The University of Glasgow was nearly made bankrupt by an unsuccessful lawsuit which went to the House of Lords in an attempt to get their graduates the right to practise surgery in the City of Glasgow itself.

Besides all this, the Colleges of Physicians in London, Edinburgh, and Dublin each issued pharmacopoeias which had no statutory authority, so that the standards of purity of drugs varied widely in different parts of the country.

The Medical Act of 1858

Such was the situation when, after many reforming Bills had failed to reach the Statute Book, Parliament finally passed the Medical Act of 1858.

The Act charged the Council with the duty of creating and maintaining a *Medical Register* containing only the names of "legally qualified" or "duly qualified" practitioners, to enable, as I have said, persons requiring medical aid to distinguish qualified from unqualified practitioners—surely a specific public interest of great importance. The Council was in fact established by Parliament to safeguard the public by ensuring that the *Register* would be trustworthy. To that end it was entrusted with twofold powers. It had authority to supervise the admission tests whereby the qualifications of practitioners were ascertained; it had authority also to remove those who after qualification had proved themselves unworthy. It is from these two powers that the activities of the Council as they are exercised to-day have slowly but inevitably been developed.

In order, then, to fix and to maintain a standard of medical education which should regulate the admission of holders of professional qualifications to the *Register*, the Council was empowered: (*a*) to require information from licensing bodies about the course of study and examinations for such qualifications; (*b*) to send visitors to the examinations, but not to the places where courses of study were held—the Medical Act of 1950 removed that limitation; (*c*) to report to the Privy Council any course of study and examinations which appeared to be so far defective that the qualification did not secure the possession by its holders "of the requisite knowledge and skill for the efficient practice of their profession"; (*d*) to direct the erasure from the *Register* of the names of persons criminally convicted or judged by the Council, after due inquiry, to have been guilty of infamous conduct in any professional respect.

The powers granted to the Council, you will see, were not great, and there was one very serious defect in the 1858 Act. It provided that every registered person should be entitled according to his qualifications to practise medicine *or* surgery or medicine *and* surgery, as the case may be. In other words, it was possible to become registered on a single qualification. Twenty-eight years later this defect in the Act was remedied by the Medical Act of 1886, which for the first time debarred any person from registration except after passing a final or qualifying examination in the three fundamental branches of medical knowledge—medicine, surgery, and midwifery. The same Act also empowered the Council to appoint inspectors (not being members of the Council) to attend all or any qualifying examinations and to report whether they are sufficient or insufficient. The 1886 Act also modified the constitution of the Council by introducing direct representation of the profession, and so also did later legislation conferring power to choose representatives from universities subsequently constituted which had established medical schools.

The Medical Act of 1950 once again modified the Constitution of the Council, which now consists of 47 members. Eleven of these are elected by the free vote of all practitioners in the four countries (seven from England, one from Wales, two from Scotland, and one from Ireland), eight are nominated by the Crown (of these three must be laymen and five registered medical practitioners), and the rest are representatives of the universities and medical corporations, one from each.

It is an interesting fact that, though Eire is now a Republic and owes no allegiance to the British Crown, the two universities in Southern Ireland (the University of Dublin and the National University) and the three Irish Corporations each have a representative on the Council. The direct representative elected by the practitioners of the whole of Ireland, North and South, who died recently, also came from Eire, and the writ of the General Medical Council still runs in the Republic.

Such is the Constitution of the G.M.C., and such are the powers granted to it by Parliament.

Functions of the Council

The first duty of the Council is, then, to see that the courses of study and the tests of professional fitness actually applied by the examining bodies are "sufficient." It has also to see that no registered person who by crime or misconduct has become unworthy of the legal status which registration confers shall remain on the *Register*. In other words, the two main functions which the Council in the public interest discharges are, first, to prevent the unfit from gaining access to the *Register*, and, second, to remove the unworthy from it. Apart from the issue of the *British Pharmacopoeia* and the recognition of Diplomas in Public Health, all its powers and all its work in relation to the medical profession have reference to these two functions. It is a Council of Education and Registration under the supervision of Her Majesty's Privy Council. If the Council neglects its duty the Privy Council may formally direct that the duty shall be performed and may in default itself perform it. The Privy Council also can do what the General Medical Council cannot do—that is, declare that an "insufficient" diploma shall no longer be recognized as legally registrable. The G.M.C., in short, is a device of government whereby Parliament controls the education and ethical conduct of the medical profession through the profession itself. That is a fact of supreme importance.

Though the Council has the power to visit medical schools, to inspect final or qualifying examinations and pronounce them sufficient or insufficient, it has no authority to lay down a compulsory curriculum applicable to all. Yet universities and other licensing bodies are naturally anxious, and indeed are entitled, to know what minimum course of study and what minimum examinations will satisfy the Council. Because of this the Council from time to time issues public statements, revised periodically, of the subjects in which students should be instructed and examined, the period to be covered by the curriculum, and the general scope of the examinations. These statements are in principle, as in fact they are called, Recommendations. They indicate only a minimum of instruction and examination; they do not impose a detailed or a uniform curriculum and they leave bodies and schools entirely free to teach and examine at a standard above the minimum. Indeed, the most recent Recommendations (1957) urged the licensing bodies and medical schools to experiment with different courses and various methods of teaching.

The Council, in short, has never tried to coerce, and indeed has no power to do so even if it wished. All the Council can do is to report any deficiencies it discovers to the Privy Council.

Standard of Qualification

The positive powers of the Council on the educational side, you may think, are not great, yet the Council has not been prevented from developing an influence which is real and potent. This result has been reached gradually by the exercise of moral as distinguished from legal pressure. It is dependent in great measure on two factors: (1) the constitution of the Council, and (2) the loyalty and conscientiousness of the teaching and examining bodies.

The fact that every university and every licensing body has its member on the Council is of inestimable advantage. That fact alone has led to the influence of the Council with the bodies far exceeding its actual powers. The only real compulsion to which the teaching and examining bodies have been subject is the internal compulsion of a high self-respect which makes them unwilling to do less than their compeers for the common good.

The powers and duties of the General Medical Council, so far as education is concerned, were, you may say, indicated rather than defined, and like many other British institutions it had in the beginning to make its way through a tangle of ancient traditions, vested rights, and sacred privileges. But in spite of the grave difficulties with which it had to contend, the fourth President, Sir George Paget, was able to say in 1874: "We know that a few years ago a man could enter our profession without producing any evidence whatever of a general education. *Now* a preliminary education is enforced upon all." And he added with prophetic insight: "The future influence of this on the social status of our profession can scarcely be overrated. We know that a few years ago only three or four of the Licensing Bodies made clinical examinations a part of their tests of fitness for a diploma. *Now* all the bodies insist on it. We know that a few years ago in the examinations for Medical Commissions in the Army it was not uncommon to find about 40% of the candidates ignorant and incapable though already in possession of diplomas in medicine and in surgery. Of late, these discreditable failures have become so few as to be almost, if not quite, insignificant."

And in 1908, when the Council commemorated its Jubilee, Sir Donald Macalister could claim with justice that the Council had been able to formulate a standard of qualification which was generally accepted, not only within the United Kingdom but in many parts of the British Dominions beyond the seas, and that it had helped to promote in a remarkable degree the improvement of the education, ethics, and social status of the profession of medicine.

And to-day I am proud to think that the general level of the attainments of the practitioners in this country are higher than anywhere in the world.

Professional Integrity

But there is another aspect of professional life. Few are likely to deny that the profession of Medicine is a great calling. Cradled in the school of Cos, it shook from itself the shackles of priestcraft and caste, declared itself at once an art and a philosophy, and established its ideals in one of the most memorable of human documents, the oath of Hippocrates. The trust reposed in the medical profession is of so great moment, the interests confided to it are so sacred, that none but honourable men and women governing themselves by the strictest rules of integrity and morality should be tolerated. Profligacy is incompatible alike with proficiency in science and success in practice.

Parliament, therefore, was wise when it gave to the General Medical Council the power, if it saw fit, to remove from the *Register* the name of any registered medical practitioner either criminally convicted or judged by the Council, after due inquiry, to be guilty of infamous conduct in any professional respect. But the Council for many years was reluctant to exercise that power. That perhaps is not surprising. For the Council was the first statutory tribunal of a registered profession called upon to exercise quasijudicial functions, the term "infamous conduct" was not easy to define, and the Council was uncertain of its powers to restore to the *Register* a name once removed. But it was fortified by the decisions of the Law Courts which declared the nature and extent of its jurisdiction, gave a progressive definition of infamous conduct, and laid down the principles which govern its disciplinary procedures. For example, the meaning and scope of the statutory verdict of the Council, "guilty of infamous conduct in a professional respect," were given by the following definition of the Court of Appeal in 1892: "If it is shown that a medical man, in pursuit of his profession, has done something with regard to it which would be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency, then it is open to the Council to say that he has been guilty of 'infamous conduct in a professional respect.'"

In this way, you will see, the guardianship of the *Register* and of its accuracy had in it the potentiality of a wider and weightier stewardship. The Council of Medical Registration had no choice but to grow into the High Court of Medical Conduct.

And following the English method of law-building with its creeping advance by limited objectives in cases that actually come to trial the Council's judgments in a succession of cases gradually built up a body of precedents and rulings which may fairly be described as forming the Common Law of medicine.

Warning Notices

The judges defined "infamous conduct in a professional respect" as something which might reasonably be regarded as disgraceful or dishonourable by professional men of good repute and competency. You can readily see how, as the standard of professional competency became higher and the ethical conscience of men of good repute became more exacting, it came about that practices which were at one time common became repugnant to the general sense of the profession. For example, in the seventies and eighties of last century it was common in some parts of the country for a registered doctor to employ a number of unqualified persons as his assistants and to entrust them with the sole care of patients. Such a practice was obviously fraudulent, and indeed dangerous to the public. After dealing with a number of such cases the Council issued a notice warning the profession against the offence of "covering" and dealt drastically with a number of offenders by erasing their names from the *Register*. The result was that in 1906 the then President could say that cases of "covering" among medical men had almost ceased to be reported to the Council, which was all for the good both of the public and of the profession.

Since then warning notices have been issued from time to time by the Council against other forms of professional misconduct which have appeared to be disgraceful or dishonourable in the eyes of members of the profession of good repute and competency. These separate notices are now consolidated in a single document known as "The Notice for Guidance" issued by the Disciplinary Committee. I need only mention two examples from that document. The Council has always taken the gravest view of a practitioner's misconduct with patients. In doing so it has not set itself up as a court of morals. The action it takes is directed to one end, and one end only—the protection of the public. The other example is advertising, whether directly or indirectly, by canvassing or touting for patients or by causing articles to appear in the press drawing the attention of the public to the superior skill of the advertiser. If such practices were permitted, it would cut at the root of all decent relationships between members of the profession, and the public might be grossly misled. For there would be no guarantee of the superior merit of the doctor with the fewest scruples in praising himself and his methods.

And here I would like to say something with regard to a criticism which has sometimes been levelled at the Council and indeed at the President. It is said that while the carefully worded notice tells practitioners in broad outline what they should *not* do, the Council has not seen fit to define in a positive sense what the practitioner *might* do. It is alleged that the Council is strangely mute or evasive when it is pressed for a pronouncement on, for example, any adjustment of conduct which might be permitted in the light of modern facilities for the health education of the public through the medium of the press or the radio or television. And it is averred that practitioners doubtful about their position in these matters receive little help of a practical nature if they address direct questions to the President or to the Council. Any hesitation to express an opinion or reticence on the part of the Council or the President is due to their statutory position. They are the judges of professional conduct in the last resort and are bound to judge every case that comes before them on the facts of the case as presented in evidence. Neither the Council, therefore, nor its President, who in fact has to deal with correspondence of this nature, can possibly commit the Council in advance to a specific view on any question which is not covered by decided cases.

I may add that the Council while indicating the desirability of anonymity in broadcasting has not attempted to prevent the publication in the press of articles on medical subjects or broadcasting by registered medical practitioners. It rests, however, with practitioners who contribute such articles or take part in such activities to exercise their discretion so as not to afford ground for complaint to the Council.

From 1858 until the Medical Act of 1950 the whole Council sat as the judicial body to consider and determine cases of convictions in the criminal courts and complaints brought to its notice. That duty is now delegated to a Disciplinary Committee elected by and from the Council. This Committee of 19 must have *at least* two lay members and *at least* six of those elected by the votes of the profession, and the Chairman is the President. The presence of lay members is a guarantee to the public that its interests will be safeguarded.

But before a practitioner can be summoned to appear before the Disciplinary Committee the facts must be considered by a small Penal Cases Committee, the membership of which, with the exception of the President, is quite different from that of the Disciplinary Committee. It is the duty of the Penal Cases Committee to determine whether there is a prima facie case,

to consider and decide whether an inquiry before the Disciplinary Committee ought to be held, or whether, if any action is called for, the case can be dealt with by the issue of a letter of warning to the practitioner concerned.

Judicial Procedure of the Council

Here, then, in brief, is the judicial procedure of the Council.

(1) With regard to *convictions* the Council normally receives from the police reports of convictions of medical practitioners for any offence. These are all referred to the Penal Cases Committee. Some of these are trivial. Others include those of convictions for drunkenness or of breach of the Dangerous Drugs Regulations (the drugs of addiction). When the conviction is the first of its kind recorded against the practitioner, the Penal Cases Committee does not, as a rule, do more than issue a warning. But should further convictions of the same type be reported, the Committee may take the view that they indicate a habit of intemperance which is discreditable to the practitioner as a professional man and may be dangerous to the patients under his charge. Accordingly, for the protection of the public the Committee may decide that the practitioner should be summoned before the Disciplinary Committee. There are other convictions of a still more serious nature, as, for example, abortion-mongering, with respect to which the Committee is bound to hold that the Disciplinary Committee ought forthwith to consider the matter in relation to the practitioner's professional status and to the good repute of the *Register*.

(2) Complaints about conduct vary, of course, in degrees of seriousness. Some of them come from dissatisfied patients or their relatives, some are made by persons obviously suffering from slight or severe mental disturbances, and some are about matters concerning which the Council is not empowered by the Acts to intervene. A number of such cases are dealt with by the President at his discretion. He may dismiss some as being trifling or vexatious; to other complainers he may reply that the proper course is to bring the complaint before another and more appropriate body such as, for instance, an executive committee under the National Health Service or the Civil or Criminal Courts. In other cases the complainant would be informed by the President that the complaint must be formulated in writing and must be accompanied by one or more statutory declarations as to the facts alleged. These are sent to the practitioner, who is asked to give such explanation of the matter in writing as he may think fit. The complaint and any explanation furnished are then brought before the Penal Cases Committee, who will decide, as I have already mentioned, whether a prima facie case has been made out to justify an inquiry by the Disciplinary Committee.

When such an inquiry takes place, both the complainant and the practitioner may be, and usually are, represented by counsel or solicitor. The hearing is normally in public and witnesses are called, placed on oath, and examined and cross-examined as in a Court of Law. The Committee has the power to compel the attendance of witnesses and the production of documents by subpoena. A Legal Assessor, who must be a barrister, an advocate, or a solicitor of not less than ten years' standing, must attend all meetings of the Committee to assist it in regard to points of law or procedure, and, if asked by the Committee, to indicate the legal weight to be attached to any evidence adduced. Both the Disciplinary Committee and the Legal Assessor in fact work under an elaborate system of Rules approved first by the Privy Council, then laid before both Houses of Parliament, and finally approved by them.

So far as a conviction in the criminal and other courts of the land is concerned, the Committee is bound to accept it as a fact. It is not a Court of Appeal. It has no power to say whether it was justified or not. All it can do is to hear anything that may be said in mitigation.

If the Committee concludes that the conviction is of sufficient gravity or that the facts proved amount to infamous conduct, it may order that the name of the doctor be erased from the *Register*. That is the only penalty provided for in the Act. But in appropriate cases, such as, for example, repeated convictions for drunkenness, the Committee may postpone judgment for six or twelve months or even longer, when the doctor has to reappear and produce evidence as to his conduct in the interval. This gives the offender the opportunity and the stimulus to rehabilitate himself, and, if he does so, his name at the adjourned hearing will not be erased.

If the decision is to direct the Registrar to erase a name from the *Register*, the practitioner has the right of appeal to the highest court in the land, the Judicial Committee of Her Majesty's Privy Council, on points of law and points of fact. It is worthy of note that since the Act of 1950 gave that right six such appeals have been made and in every case the decision of the Disciplinary Committee has been upheld.

Finally, a practitioner whose name has been erased may, under the conditions set forth in the Rules approved by Parliament, apply to have it restored to the *Register* at any time after the expiration of 11 months. It is the practice of the Committee to accede to such applications when it is satisfied that this course may be taken consistently with the public interest.

I hope I have been able to show that the Council does not act as prosecutors against practitioners. Through the medium of the Disciplinary Committee it is a judicial body which takes action only in cases of criminal conviction or in cases of formal complaint made by responsible persons or bodies and supported by prima facie evidence. The judicial procedure is based as nearly as may be on that obtaining in the Courts of Law. When a charge is made the practitioner has every possible opportunity of defending himself. If the Committee resolves to erase his name from the *Register*, he can appeal to the highest court in the land, and should his name be erased it may subsequently be restored if that can be done with safety to the public.

"British Pharmacopoeia"

In its task of preparing the *British Pharmacopoeia* the Council had from the very beginning to invoke the assistance of members of the pharmaceutical profession, and owed much to their expert advice. But if you compare the first *British Pharmacopoeia* published by the Council with that of 1958 you will get some understanding of the enormous advance in medical science, especially during the last half-century—greater, indeed, than in the past two thousand years. And you will realize why it became imperative that, while the Council might continue to publish the *Pharmacopoeia*, its

preparation should be in the hands of a special body of experts—chemists, pharmacists, pharmacologists, and microbiologists as well as physicians. Thanks to the work of that special body, the British Pharmacopoeia Commission, the Council has been enabled to publish perhaps the best *Pharmacopoeia* in the world.

Dentistry

Eighty years ago the Council had added to its functions the duty of keeping a *Register of Dentists*, thereby becoming responsible for the standards of education and discipline of the practitioners of that art. Dentistry as a profession did not in fact exist at that time, yet the General Medical Council, working on the precedents already established in its guidance of the medical profession, had by 1921 not only created a profession but was able to hand over to the Dental Board of the United Kingdom the supervision of a profession whose standards of education and ethics were enormously improved. And to-day we have the youngest body entrusted by Parliament with the responsibility of maintaining standards of professional education and ethics, the General Dental Council—the mirror image of the General Medical Council.

Overseas Qualifications

Another important activity of the Council is not perhaps so well known. The Act of 1858 permitted the Council to register persons with foreign qualifications only if they were practising in this country, but a later Act authorized it to recognize medical qualifications granted in Commonwealth and foreign countries provided it was satisfied of their sufficiency. It could then register practitioners with such qualifications, but only on the basis of reciprocity. With few exceptions we have now reciprocity with all the countries, states, and provinces of the Commonwealth. And such is the prestige of the British *Register* that last year more than 2,000 practitioners from all parts of the Commonwealth sought to have their names inscribed thereon. And at the present moment there are more than 13,000 names of Commonwealth practitioners on the *Register*.

This desire of the medical schools overseas for the recognition of their qualifications by the General Medical Council led the Council to send visitors to various countries of the Commonwealth—India, Africa, Malaya, and Hong Kong—to advise, to encourage, and to assist the medical schools there to raise their standards.

But it is not only the standard of medical education which has been raised. Councils and Boards have been established in many lands fashioned on the pattern of the General Medical Council and working on the educational and disciplinary precedents established by it. I have visited on behalf of the Council all the countries of the Commonwealth, and could not help being impressed, and sometimes perhaps a little proud, when I was told how the Councils and Boards overseas welcomed and relied on our experience and advice.

I said earlier in this lecture that I was proud to think that the general level of attainments of the practitioners in this country were higher than anywhere in the world. I believe also that the ethical standards of the profession in this land of ours are higher than in any other country.

The Licensing Bodies

But it would be foolish to assert that the achievements I have described are entirely due to the General Medical Council. Much of it is due to the admirable spirit which pervaded and still pervades a profession animated by the ideal of service to the community, and much of it is due to the licensing bodies, especially the universities of the country.

It is a sad thought that though the Papal Bulls establishing three of the four Scottish universities enjoined that Medicine should be cultivated as well as Theology, Canon and Civil Law, and the liberal arts, the universities of Scotland, like the still older universities of Oxford and Cambridge, devoted themselves in the main for centuries to the great authors of the old classical ages, to Aristotelean philosophy and to the civil law of Rome, and Medicine was comparatively neglected. How much better for mankind if, while not ignoring the precious legacies of Greece and Rome, they had cultivated medicine as well as letters, scholastic disputation, and scholastic divinity. Divinity has often been called the Queen of the Sciences, and in a sense that is true. But Medicine has always been the foster-mother of the Sciences.

But last century saw a resurgence of the study of Medicine in the older universities while the younger universities of England, often indeed having their origin in pioneer medical schools, vied with the older in advancing the teaching of Medicine. And all of them have set an admirable example by supporting the Council with a most praiseworthy public spirit.

Great Achievements

Looking back, then, over the past hundred years, the General Medical Council, with the support of the profession, the Licensing Bodies, and the Law, has been able to achieve great things in spite of scanty powers it originally received.

It has helped to promote in a remarkable degree the improvement of the profession of Medicine. That improvement is apparent to anyone who recalls the conditions of professional life, educational, ethical, and social, that prevailed a hundred years ago. It has created the profession of dentistry and made it a self-governing body. It has by its example and its precedents helped to establish throughout the Commonwealth bodies charged with the task of improving medical education and ethics. And by its visitation, encouragement, and advice it has stimulated the advance of medical education in many lands overseas. It has in fact become the model for the organization of other professions both in this and in other countries.

The protection of the public was the chief reason for the establishment by Parliament of the General Medical Council. It has always been, and still is, the primary duty of the Council. It is the thread which unites all its diverse-seeming activities—medical education, the registration of doctors, disciplinary jurisdiction, and the *Pharmacopoeia*. I hope that the outline I have given you of its work will satisfy you that it has not wholly failed in the tasks committed to it.

In the preparation of this lecture I have made considerable use in the light of present-day circumstances of (1) the admirable "Introductory Address on the General Medical Council, its Powers and its Work" delivered at the University of Manchester by the then President Donald Macalister and printed in the *B.M.J.*, 1906, **2**, 819, and (2) The "Memorandum on Constitution, Functions, and Procedure" published by the General Medical Council, 1939 (Revised 1949), which is mainly based on that address.